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ABSTRACT

Two papers examine proposed programs for the disabled in developing nations of Asia and practical drawbacks to integrated education for handicapped pupils in developing countries. The first paper contrasts government rehabilitation policy and planning in Asian countries with the strategies currently advocated by international organizations in the disability field. It examines the motivation behind government plans for large disability complexes, and enumerates the problems likely to be encountered by the community rehabilitation proposals promoted by the World Health Organization. The author suggests a "middle way" based on experience in Pakistan which would mobilize community resources in small inexpensive day centers providing a realistic level of rehabilitation while being open ended toward more, and less specialized, programs. The second paper points out the serious problems in normal schooling (such as much rote learning) in the developing countries and concludes that handicapped students are only occasionally well served in this setting. (DB)

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MISPLANNING FOR DISABILITIES IN ASIA

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MISPLANNING FOR DISABILITIES IN ASIA

This paper contrasts Government rehabilitation policy and planning in some Asian countries, with the strategies currently advocated by international organisations in the disability field. It examines the motivation behind Government plans for grandiose Disability Complexes; and enumerates the problems likely to be encountered by the Community Rehabilitation schemes promoted by the W.H.O. with U.N. backing. A 'Middle Way' is suggested on the basis of experience in Pakistan to mobilise community resources in small, inexpensive day-centres providing a realistic level of rehabilitation while being open-ended towards both more and less specialised schemes.

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1. INTRODUCTION.

Pakistan and its immediate neighbours, India, China, Afghanistan and Iran, make up a sizeable portion of Asia both in area and in their combined population of 1.7 billion. Rehabilitation work in Iran is suspended due to the internal problems of that country, and will presumably take many years to pick up again. The joint initiative of setting up an International Centre for the study of rehabilitation in developing countries, in Teheran, unfortunately never reached a useful functioning level. (It is to be hoped that the experience gained will be deployed in another country with better results.) In Afghanistan the need for rehabilitation of disabled persons barely gains official recognition (spokesmen at international gatherings have been known to state that there is little disability among Afghans since the Revolution has solved all the problems of the people). A small effort is currently being restarted in Kabul despite the difficult situation there, for rehabilitation of blind and physically disabled persons.

In China there have been a few experimental classes for mantally retarded children, some special schools for mixed disabilities, the treatment of hearing loss with acupuncture, and nationwide efforts to prevent disabilities by basic hygiene and improved midwifery. It seems unlikely that the Chinese Government will be seduced into setting up expensive prestige projects for the handicapped. On the contrary, the W.H.O. Community Rehabilitation schemes might find very fruitful ground in the extensive existing primary health care system.** Rehabilitation facilities in India are 20 or 30 years ahead of developments in Pakistan, but mostly in a direction that would seem regressive to western rehabilitation advisors. The International Year of Disabled Persons has seen a new crop of grandiose schemes for immense residential projects, even a whole 'disabled village'. India is so large that there is little effective central co-ordination. The Federal Government tried to promote integration of handicapped children in normal schooling by the offer of large-scale aid to set up such schools. There were hardly any takers over a 5 year period. However, there are sufficient indigenous resources of experience, equipment and specialist staff, that any sensible rehabilitation policy would be able to start in several places and get a fair trial.

This paper arises out of three years working with handicapped children in the North West Frontier Province of Pakistan, running special schools, advising the Government on the most appropriate strategies for developing facilities for handicapped persons, and attending professional conferences on the subject.

**A similar conclusion was reached after detailed study by J. Dixon "The Welfare of the Handicapped in the P.R. of China", J. rehab Asia, Oct.81

The immediate spurs were: (a) a month-long trip through India visiting rehabilitation centres and attending a major Congress and a workshop on epidemiology, financed by the Rosemary Dybwad International Award; (b) an evaluation exercise on the new W.H.O. Community Rehabilitation manuals; (c) discussions on development with U.N. advisers in other fields, and with a rehabilitation counsellor from Afghanistan; (d) the discovery that five Western rehabilitation advisers who have visited Pakistan in the past year have given mutually contradictory advice.

During the past three years which included I.Y.C. and I.Y.D.P. there has been much talk about handicaps in Pakistan, and I have contributed my share of comment and advice to the Government. Such advice as I have given has been along similar lines to that pumped out by the W.H.O., UNICEF, Rehabilitation International and other bodies with world-wide experience. It has been almost totally ignored by the Government of Pakistan, and there is every indication that the mere repetition of such advice will equally be ignored for several years to come. In actual fact the Government is planning to do a number of things which it has strongly been advised not to do.

There are three broad trends in Pakistan at present in development of special education and rehabilitation. There is a move to improve and expand existing facilities for special education. Plans are being implemented to build huge 'Disability Complexes'. The W.H.O. Community Rehabilitation scheme is appearing on the horizon. Pakistan is a sufficiently large nation for there to be room for several different initiatives in developing facilities for handicapped persons. Nevertheless the lack of coordination between the three trends is damaging to all, and they will inevitaoly be in competition for official backing and resources. It is therefore worth while examining these trends to see why they are taking place, and what is their likely outcome.

The following discussion is relevant to much of Asia, and also to some other parts of the less developed world. No attempt has been made to follow W.H.O. terminology of impairment/disability/handicap. In Pakistan we are at the stage of terminology where the 1981 National Census included a question listing disabilities thus: "(1) Blind; (2) Deaf and Dumb; (3) Crippled; (4) Mad (Urdu - Pagal); (5) Half Mad (Urdu - Nim Pagal, to denote mental handicap); (6) Other".

2. CURRENT TRENDS.

a) Improving Existing Facilities.

During the past three years the Government has taken steps to inform itself of what facilities currently exist for the handicapped, who runs them, how much they do and at what cost. Quires of questionnaires issued forth from Government Ministries in the hope that voluntary welfare associations would supply the information. It soon became obvious that the Government enquiries were not being coordinated between Ministries, and that the welfare organisations had neither the time nor the inclination to fill in questionnaires. However, the Government formed an impression that there was some activity going on for the handicapped, much of it run by N.G.O.s, almost entirely confined to the Provincial capitals and at a fairly low level of professional competence.

The Government itself runs a number of schools for the deaf and for the blind. These have mostly been rather depressed institutions, due in part to the absence of a cadre of special education officers. The schools have mostly been run by generalists from the Education Department who have stayed a few years and then have moved back into general education. From a career point of view there would be no future in remaining as a Principal of one of these special schools. (In the absence of adequate training courses for specialists, the Government has had no option in the matter.) Some schools for the mentally and physically handicapped have also been run by voluntary welfare agencies. In a few cases they have had foreign-trained personnel and foreign funding, but in the main they have suffered from financial difficulties and lack of adequate and appropriate skills. Both in the Government and the N.G.O. sectors there has been an urgent need for improving existing facilities.

However, to improve has not been easy. Staff sent abroad for training either do not return, or return with inappropriate skills and expectations geared to Western rehabilitation facilities. The President of Pakistan, addressing medical specialists recently, remarked that of those going abroad for higher studies, 6 out of 10 simply refused to come back, while 2 out of the remaining 4 come back with great reluctance and delay. It has not even been easy to find appropriate people to send, who have both experience with handicapped persons and sufficient education to be able to benefit from a course abroad. Some of those who have been sent have returned to administrative posts where they are not in fact making any use of what they learnt abroad.

The Government has also tried inviting well-qualified foreigners to Pakistan. However, while 'foreign experts' have their uses in bringing experienced professionals up to date with the latest advances in a field, they are at a great disadvantage in giving basic training

in rehabilitation, which cannot be taught or learnt simply from books and lectures. It is essential that practical demonstrations be given, and for that some familiarity with local languages and customs is essential, particularly in special education. Handicapped children are rarely able or willing to learn from a teacher until a relationship of trust and confidence has been established, using language or the cultural signs and non-verbal indicators with which the child is familiar. Foreigners are rarely much use unless they are prepared first of all to spend at least one year gaining basic language and cultural insight and adapting their methods and techniques to the cultural requirements of Pakistan.

Most of the existing facilities for the handicapped have been poorly equipped. When the Government desired to equip them better it discovered that little of the required equipment is available in Pakistan, red tape abounded to prevent its import, and there were the usual problems of servicing sophisticated imported equipment. (The Principal of one school for the deaf brought 200 hearing aids back to Pakistan with him after a training course abroad. Within two years not a single one was functioning. He therefore abandoned Oral Education of the deaf and now uses only Signing methods.) The bureaucrats wrestled with the dilemma that much of the special education equipment for handicapped children, which should be duty-free, in fact consisted of good educational toys, which carry heavy import duty. When they turned to the sole manufacturer of Montessori equipment, a one-man Karachi business, he told them that he was now ashamed of his own wares because over the years the Government had successively banned import of all the hard woods he needed for high quality work.

The existing special schools almost all run in cramped, inadequate or ramshackle accommodation, and many have problems with daily transport of pupils to and from their homes. Most of the Government "improvement" plans have therefore taken the form of large grants for new buildings and vehicles, which are easy to get hold of compared with the acquisition of professional skills. The possibility of achieving these objectives has led to bitter internal struggles within several voluntary welfare agencies, with wealthy ladies vying for the prestige of bring President of an expanding Handicap Association and taking every opportunity of parading their philanthropic activities and denigrating the work of others. There has also been cut-throat competition between voluntary welfare agencies once it was learnt that the Government intended to take one of each type of handicap institution in each Province and turn it into a 'model centre'. Each agency saw its opportunity to become big and well-known, and each one also saw the danger of becoming small and ignored if it did not achieve selection for 'model' status.

The Government's intention to improve existing facilities has been laudable, but by and large implemented in a naive fashion so that handicapped adults and children themselves have seen very little benefit from it. The exercise has been run 'from the top downwards' with a strong smell of money sloshing about, in the worst tradition of development aid. There has been no coordination between the Ministry of Education, the Ministry of Health and Social Welfare and the National Council for Social Welfare, each of which runs its own show and makes its own plans with a spirit of rivalry rather than cooperation. This lack of coordination resulted for example in the National Council for Social Welfare not being invited to send a representative to the National I.Y.D.P. Committee, in the setting up of no less than three independent prosthetics workshops in one year in one provincial capital, amidst bitter competition for trained staff, while nothing whatever has been planned for the rest of the Province; courses of speech therapy were provided for teachers of the deaf, but apparently nobody in the Ministry concerned realised that speech therapy also plays a major part in rehabilitation of the mentally retarded; a survey of physically disabled children in normal schools got lost in the backwash of petty bureaucracy and inter-departmental jealousies.

b) Prestige Disability Complexes.

Nobody seems to know just how many grandiose schemes are afoot for Disability Complexes. The Education Ministry and the Ministry of Health and Social Welfare appear to be running parallel schemes in mutual ignorance. The Islamabad Capital Development Authority may have its own scheme, or it may turn out to be part of a Ministry scheme. One Complex will probably be part of a gargantuan National Hospital. One Complex is half-way to completion in Baluchistan. All these Complexes have been planned and undertaken either in ignorance or in flat contradiction of the advice given by international agencies in the rehabilitation field. It is of interest therefore to consider why they have been planned and are even now being built. The author of one scheme commented in a national consultation on handicapped children that he himself was opposed to it but had been ordered from higher up to produce a plan. Somewhere in the hierarchy there must be a desire for Disability Complexes, and this desire needs to be examined carefully.

Visibility. The Disability Complexes will be highly visible, both from the prestige point of view and that of demonstration. It is politically useful for the Government to be able to say to its own people "See what a very large and impressive provision we have made for the handicapped". Like other prestige projects, they serve

several purposes. They draw public attention to a facility and put it 'on the map', which is useful in the case of disabilities since the prevailing attitude is to ignore handicapped people or to put them out of sight. They boost the confidence of Government officials who are able to show foreign visitors what an impressive modern institution has been erected for the disabled. They proclaim that Pakistan is not merely a nation of peasants living in mud huts and scraping a living out of the soil. The psychological value of the prestige project should not be under-estimated, since the entire development of Pakistan is crippled by lack of confidence and poor world-wide image. Prestige projects may help overcome those national handicaps. They may also give a boost to rehabilitation professionals who have for long been the cenderellas of the health, education and welfare world. Even if they are not able to secure jobs in the prestige scheme, they may feel that it indicates the dawn of official interest in their field.

So far as demonstration is concerned, if the prestige Disability Complex were in fact a 'model' to be imitated or emulated elsewhere, then the more visible the better. Compare, for example, the opposite end of the spectrum, the Community Rehabilitation scheme: however well it works in any locality, it will lack visibility and thus be more difficult to publicise and duplicate. To 'visit' a Community Rehabilitation scheme would mean visiting a number of homes, many of them very humble, spread out over a possibly wide area. People will not easily be impressed with it unless they already know enough about rehabilitation and development not to need to visit it. Whereas the prestige project may impress people, and is easy to visit. The snag is of course that if a project is big and expensive it is not likely to be duplicated very widely.

Planners, and Governments as a whole, like to see the results of their activity, to take pride in them and to leave what they believe to be a worthy monument behind them. They also like to feel that they have caught hold of a problem and given it a good wallop. The grandiose building for the handicapped satisfies these inclinations. It also appears to encapsulate the problem. If one can have 100 disabled people getting treatment in one place, then why not 500? or 1,000? And of all species of handicap. with every possible type of equipment, specialist, therapist. All under one roof. Neatly tied together. Just as they have (or are imagined to have) in America.

Models. Belief in setting up model centres has declined somewhat among Aid personnel over the past ten years or so, since it became evident that the 'model' centre is almost by definition so atypical from conception through to the finished product that it can never be copied, or at any rate very rarely is copied elsewhere. However, during this period of time the term 'model centre' has been much bandied about and has passed along with much other development jargon into the subconscious of planners in developing countries, from whence it surfaces with a reflex jerk whenever something new and worthy is proposed for which scanty resources are available.

Sometimes it is confused with the phrase 'centre of excellence', which is certainly a model in one sense of the word, i.e. a centre which maintains very high standards to which all others may aspire, but that is scarcely a model in the other sense, i.e. a standard type which may readily be duplicated. It is not surprising that planners should fall into wishful thinking and believe that they are setting up a 'model centre of excellence' which somehow, producing an abundance out of nothing, will be duplicated to produce excellence all over the place.

The realistic development model centre would start with typical conditions and average staff, and aim to demonstrate that with new methods or improved techniques much better results can be obtained for the same average input. Needless to say this rarely takes place. The temptation to load the odds in favour of success is overwhelming, even if to do so undermines the whole experiment.

The Influential. The rich and powerful in every country, in whose hands (or under whose influence) is the planning and financing of projects, always have planned and presumably always will plan for the maximum benefit of the rich and powerful. It is very difficult for them to do otherwise, since the very fact of their own power and wealth limits their understanding of the world, and were they to do otherwise, they would very soon cease to be rich and powerful. However, if some benefit accrues incidentally to the masses of powerless little people, the planners are very happy. It soothes their conscience, and also serves to take the edge off the bitterness of the powerless. All across the Development board, whether it is Agriculture, Education, Health, Housing or Welfare, occurs the same problem of distribution. The few who have much can always arrange to be supplied with more; the many who have little tend to lose even what they have.

When it comes to rehabilitation facilities, the rich and powerful are obviously more concerned to have in their country a few prestige centres of international standard which can give first-class treatment to a small number of persons per year, than to have hundreds of modest local day-centres giving a lower standard of rehabilitation to thousands of people, or to have a home-based Community Rehabilitation scheme giving a small boost to several hundred thousands.

In the past, and still to some extent today, the wealthy have gone abroad for rehabilitative treatment for their children. However the cost of treatment in the industrialised world has become extremely high, due in part to the surge in salaries of lower grade workers in the west and the increasing differential in living standards between the 'haves' and 'have nots'. Since the salary surge has not taken place in the Fourth world it appears feasible to set up and run advanced rehabilitation facilities much more cheaply, using exploited labour in Fourth world countries. It is therefore no surprise to find that grandiose Disability Complexes follow hard on the heels of prestige Disease Palaces set up in major cities of Asia, despite western advice that a more appropriate and more widely distributive scheme of health and welfare should be planned.

For westerners to complain about this is usually hypocritical, in that most westerners would be very reluctant to accept a substantial decline in their own standard of living and enjoyment of facilities in order to share economic power with nations less well endowed. There is no more reason to expect wealthy and influential Asians to plan to give away their privileges on the national level, than to expect westerners to do so on the international level. It is also the case that just as most westerners are ignorant of the real living conditions of most Asians, so the rural handicapped and poorer urban disabled persons of Asia are invisible to the wealthier Asians. They simply do not realise that the problem is there, and in large numbers, and that the people are real flesh and blood like their own flesh and blood.

The move towards provision of residential places for the handicapped also finds some of its strongest support among the well-to-do. There would in fact be no difficulty in setting up and financing private big-city residential homes for severely handicapped persons: such homes would be over-subscribed from the first day, by families who wish to rise in career and society without the 'hindrance' of a handicapped child. Such families are not however good supporters of day centres. They can instead afford private tutors or nurses at home: but such measures are too slow and lack ultimate success. The best solution is to pay large sums to put the child right out of their lives.

Because these families exist, are wealthy and have influence, it is practically impossible for rehabilitation to develop solely along the sort of 'appropriate' lines envisaged by western rehabilitation advisers. (Even revolutionary socialist states have failed to weed out the insidious 'islands of privilege' among the drab lowest-common-denominator of state services.) Wealthy families will always be there offering large sums of money for specialist treatment or for residential institutions for their handicapped members. (It is a tribute to the fine character of our own Pakistani staff that several have turned down very lucrative offers of personal tutorships to the handicapped children of the rich, in order to continue working for low pay at the Mental Health Centre.)

Once there are some high-level facilities in existence, any lower level of professional competence or any more demanding form of rehabilitation (like the Community Rehabilitation scheme, which throws the burden back onto the family) will be compared and contrasted and found less attractive by planners and consumers. It is an old and well-established fact that as long as there are no Mercedes cars in a country, Government ministers will be content with a Volkswagon. The day that one minister acquires a Mercedes, the rest of the Government cease to be content with their Volkswagons.

An incidental problem which may be foreseen in the work of the expensive, specialised rehabilitation facilities currently being planned, derives from the social class and expectations of the wealthy families who will patronise them. The sort of vocational skills and crafts acceptable by such families for their handicapped offspring are very different from those appropriate to the lifestyle of most of the population. Many mentally handicapped people, for example, can usefully and enjoyably be trained in gardening skills and other quite humble occupations. However, it is unacceptable to rich families that their child should do any such menial work, whatever its therapeutic value. Thus the wealthy families will ensure that even if some handicapped persons from poorer families manage to gain admission, the type of vocational training provided will be inappropriate.

<u>The Highly Qualified</u>. Allied to the wealthy and influential planners and Government ministers are the highly qualified medical personnel, psychiatrists and psychologists, who return to Pakistan after gaining skills and experience in the West. Whatever their motivation for returning to their country, they are often worse than useless as agents of development, having become thoroughly westernised and determined to accept nothing below the professional and living standards to which they have become accustomed. Some are infused

with an overwhelming sense of the sacrifice they are making in leaving the West, and feel that they are more than entitled to any perks they can pick up. Such people often know nothing about the living conditions of the masses in their own country. The majority of professionals who succeed in going abroad for further experience and training originate in the wealthier sections of society, which gives them the initial head start on the educational ladder plus the influence necessary to gain scholarships to study abroad and the capital to set themselves up overseas. They may return with notions of doing some good to their old country, but the only thing they really know and understand is how to work the sophisticated systems of the West.

These people tend to accentuate the divorce existing between white-coated professionals and technicians in the rehabilitation world, and the lowly class of ayahs and junior teachers who actually make physical contact with handicapped children. Nowhere is this divorce more clearly seen than in the field of Physiotherapy. The art and science of massage and manipulation has a venerable history in the sub-Continent, and is potentially a very great indigenous resource to combat physical handicap. However, the trained Physiotherapists with their three year degree of B.Sc. regard themselves as much too well-qualified to use their hands in physical contact. They are qualified to flick switches on expensive electrical machines, into which their aides and subordinates place the handicapped person. Like the bazaar psychiatrist with his electric shock machine, they are set up for life once they can acquire their own expensive gadgetry with which to carry on private practice.

A school for retarded children was set up with much publicity in one city of Pakistan, and with much pushing and jostling among society ladies for prominent positions as Ladies Bountiful. One or two young ladies with M.A. Psychology proposed themselves to be In Charge of the teaching side. After a few days experience with severely retarded pupils it was realised that several were incontinent and several would never be capable of showing acceptable results by learning their ABC or producing fine craftwork. In a series of hasty manoeuvres the 'hopeless' children were dropped, an ayah was hired to clean up the incontinent, and some children with mild physical handicap were drafted in so that 'results' could quickly be obtained and the wealthy ladies achieve the desired glow of self-satisfaction over their own munificence towards "these poor handicapped children". The ayah, who actually cuddled the children and sat on the floor playing with them was very soon the sole rehabilitative asset of the school. She was of course paid very little, since her work was regarded as unclean and menial. When she proposed to leave for a job where she was not only

paid better but would herself be treated with respect as a human being, the wealthy ladies woke up too late to the fact that the ayah was the only person doing any appreciable work with the children.

Empire and Ego Building As has already been implied, the personal ambitions and aspirations of planners and philanthropists play a considerable part in decisions about strategy for rehabilitation. Perhaps it is indelicate to point this out; but there is often a hint of indelicacy about the reality of rehabilitation work. Disabled people are singularly defenceless against the drives and ambitions of non-handicapped people. Both in the private and the Government sectors there is a strong drive towards setting up little empires, with one supreme ego sitting in command of scurrying minions. Given a choice between enormous, centralised handicap palaces, small local day-centres, or home-based community rehabilitation, there is no doubt where the majority of rehabilitation professionals will cast their vote. To expect them to opt for the humble schemes with very low professional ego-gratification, is to ignore elementary psychology.

Examples abound in Pakistan of thriving rehabilitation work being taken over by interfering busybodies, sometimes after a stiff battle, and then being maintained on paper while falling to pieces in practice. Leprosy work in the North West Frontier was taken over in this way, the key figures being driven out in a two-year campaign by a person who wanted to gain control of their work. One former leprosy patient who had been rehabilitated to the extent that she was earning her own living with a sewing machine in her own village, was approached by the busybodies who commiserated with her on her ill-fortune in being discharged from the leprosy base hospital, and insisted on taking her into their own hospital to look after her for life! work for the blind both in Karachi and Lahore has needlessly been taken over and pulled to pieces with no thought for the welfare of the handicapped persons, but purely in the enlargement of some so-called philanthropists' private empires. A school for the mentally retarded in Rawalpindi was involved in a three-year battle for control, precisely at the moment when large Government grants became available. The first casualties, of course, were the retarded pupils who stopped attending even as a start was made in putting up new buildings.

Even some quite well-conceived U.N./Aid agency projects can be guilty of major disruption to existing rehabilitation work, by their weight and magnetism. One week before writing this our physiotherapist was offered double his present salary to go and work with a refugee aid organisation: to exchange his present work of healing crippled children (both Pakistani and Afghan) for a job treating solely Afghan war wounded. Fortunately the man concerned is a good

Muslim believer who cannot be bought and sold, and we were able to negotiate for him to work in his spare time with the other agency. During the past 6 months we have had requests for our participation in various international projects, with sizeable inputs of money. The projects are good, and we need the money to maintain our own base, but we know from past experience that to go into these projects would swamp the rest of our work. It is very difficult for U.N. agencies to do anything on an appropriately modest scale. Where large sums of money are available there will be a strong tendency to use them, especially if they do not represent a large amount in the minds of U.N. officials. A sum of 50,000 U.S. dollars seems quite modest to an expatriate official who himself earns more than that in a year; but in Pakistan it is enough for a year's entire running costs for 5 special schools totalling 100 retarded pupils, or for eye camps in which 10,000 people could receive their sight again.

One of the major difficulties in giving 'more aid to the poorest' in the rehabilitation field, is that 'the poorest' simply do not have enough rehabilitation practitioners to cope with new projects. There has to be a good deal of coordinated planning in order to increase supply of appropriately trained staff and at the same time start up new projects to absorb them usefully. Such planning also needs to be hard-headed, to avoid duplicating the muddle of doctor training in Pakistan: plenty of young doctors have been trained, and there are many posts waiting vacant in rural areas. However, the doctors prefer to sit idle in the cities and try using influence to get a city post. They cannot be persuaded, bribed, coerced or by any means be driven out into the rural areas. The first Government-organised training course for teachers of the mentally handicapped is likely to take place in Karachi; and nothing will persuade the fruits of that training course to come even to cities like Peshawar, which are regarded in much the same light as is Siberia by Muscovites.

Evolution. The Joint Commission on International Aspects of Mental Retardation (Report, Jan. 1980) recommends that developing countries should by-pass the historical development in care (e.g. the building of large institutions). This recommendation is understandable, but for reasons already described it will largely be ignored. I doubt if it is possible for countries to jump down the evolutionary path, by-passing any stage of development. The various stages reflect the evolution of public opinion and awareness, plus the availability of resources (which again depends partly on public willingness to pay and provide). Besides, institutional buildings serve to encapsulate the problem, which always has more appeal for the bureaucrat.

than a loose, straggly problem spread out thinly all over the community. Individual developments may jump a stage or two, but if they get too far ahead of the broad wave-front they will simply have to mark time until the rest, such as Government policy, staff and equipment supply, can catch up. And marking time is no easier for an institution than for a bicyclist.

The Joint Commission's recommendation is in line with a belief that development is about policies and strategies; whereas in fact development is primarily about people. People take time to adjust their views, and even longer to adjust the philosophy underlying their views. Copernican flashes of insight are rare enough in the individual, and practically unknown for people en masse. It may be realistic to plan to head people off from some of the blinder alleys of evolutionary development, and to try to hasten their progress through certain parts of the main stream, but unrealistic to hope for a bunch of kangaroos hopping merrily down the optimal path.

c) Community Rehabilitation.

It has already been pointed out that C.R. schemes will have little appeal to the professionals. And despite some sales talk from the W.H.O. team pushing Community Rehabilitation proposals, the scheme has no chance of success without a considerable measure of active support from rehabilitation professionals. Nevertheless, it is quite likely that it will succeed in being launched in Pakistan in a small way, just as Primary Health Care schemes have been launched to an extremely lukewarm reception by the medical profession. Once the planners have made sure of their islands of privilege, those huge rehabilitation projects which will look after the handicapped from wealthy families, they are not against throwing a few crumbs to the rural masses 'out there' in 'remote villages'. The presentation of the W.H.O. scheme is well adapted to reinforce this 'remote village' concept, and it is being sold as a very cheap scheme, all of which appeals to planners and politicians.

The likelihood is that as long as there is foreign support coming in for the Community Rehabilitation scheme, and as long as there are free trips abroad for consultations, and a general flurry of apparent activity and money being thrown around on additional staff, planning cells, seminars, community rehabilitation officers, reports, evaluation of reports, research grants for baseline data etc., there will be vague Government approval for the scheme. These initial stages can be spun out for two or three years without a single handicapped child being benefitted. However, when the initial burst

of enthusiasm and foreign capital dies down, the official interest will die too. The Health and Social Welfare officials have no reason to turn down overseas assistance, as long as it lasts. The overseas agencies will try to tie up the scheme so that what they start must be carried on by the Government, but such promises are easily made, easily broken, and the break easily disguised so that overseas aid will continue to roll in for other new projects.

Instead of rushing into Community Rehabilitation, it would be sensible if the W.H.O. and interested Government took a long hard look at their experience with Primary Health Care, where there is ten years' worth of hard-won experience written up for the warning of future enthusiasts. The authors of the Community Rehabilitation scheme appear to have studied a certain number of P.H.C. manuals but there is little evidence that they have also applied themselves to reading critical evaluations of P.H.C. schemes. Yet the following problems into which P.H.C. schemes have run in Asia will all have their equivalents in Community Rehabilitation efforts, both here and most probably in many other parts of the world.

1) Opposition from professionals in the health field, and the inertia of the status quo; plus nowadays an increasing strength of opposition to all schemes originating in New York, Geneva or Stockholm.
2) Opposition from local communities, who have become suspicious of the development worker's latest ploy after two 'development decades' of bright schemes and pilot projects. Local communities are often quite well aware that if they accept a couple of P.H.C. workers then there is no chance of getting a village hospital with doctor and nurse, whereas if they hold out for the traditional pattern they might eventually get somebody with influence to give them what they really want. (Rural folk are often in less of a hurry than western city-based advisers.)
3) Difficulty of finding suitable front-line personnel: the ones most acceptable to the local community tend to be older, less literate, less flexible, less ready to grasp and implement the required methods; whereas the more easily trainable younger ones cut less ice in the community. The ones who do well in training and implementing the scheme naturally have career ambitions and do not expect to remain forever as voluntary or poorly paid workers at the bottom of the pyramid. In many places there are mobility restrictions on female workers, and by the same token there is no access for male workers to female clients.

4) Preventive health, hygiene and sanitation education invariably gets neglected in favour of curative medicine, since the latter brings quick, visible results (sometimes linked with a small financial gain from sale of drugs), whereas the former does not.

5) P.H.C. workers need adequate supervision, back-up, encouragement, referral system and regular refresher courses or further training, if they are to function well and retain some enthusiasm for their work. All of this requires a considerable administrative structure and competence, in an area of shortage. The 'Health and Health Related Statistics' published by the Government of Pakistan for 1978 show that in rural areas 99% of the paramedical posts were filled, whereas 66% of the doctors' posts and 44% of the nurses' posts were lying vacant (a shortage roughly 3 times worse than that in urban areas).

In addition to problems equivalent to the above, the following difficulties are likely to be faced by C.R. workers:

6) There is far greater public prejudice against handicap than there is about illness. In most places there will be a tendency to conceal handicapped members of a family, partly out of shame, partly in order not to spoil the marriage chances of other members. Thus before any rehabilitation can take place, the handicapped must be found and their families persuaded to make public their disability.

7) The P.H.C. worker does at least treat patients directly; whereas the C.R. scheme envisages two removes: the Local Supervisor (with a few weeks training) tries to find a family Trainer (who gets a few hours orientation), while the main fount of wisdom is a manual. In most parts of the developing world there is no tradition of reading, assimilating and referring back to the printed word. Even if as many as 30% of the adult population is 'literate', less than a quarter of them are likely to have the <u>habit of reading</u>. (Any doctor in the 95% literate western world who gives out pamphlets of advice at his surgery is accustomed to finding his front steps and the road nearby littered with the same pamphlets in a screwed up condition.)

8) Families with a handicapped member come to the specialised rehabilitation facilities in the big city, hoping for a cure. When we tell them that there is no cure, but that years of determined effort will very probably result in a transformation of their handicapped relative, they are often not interested. They want a cure, not hard work. If we, who have some status as Western and Pakistani professionals, fail to convince many of these families, the C.R. worker is going to be even less convincing.

9) Compared with health care, where results can show up within a few hours or days of treatment commencing, improvements are likely to be slow in C.R., and with the mentally retarded barely perceptible. Most of the retarded children we see have some degree of disturbance, and it may take 6 months or more of intensive work to overcome this. The average child takes several weeks to overcome negative behaviour patterns learnt within the family. The daily escape to school provides a chance to start again at making relationships. This is of course not possible with the C.R. scheme, where it is precisely the family who do the training, though they may in fact present the greatest psychological obstacle in the initial stages.

Experience in the West of helping families to participate at home in the progress of their retarded child has shown that this is practicable only where extremely detailed child development charts are available in terms comprehensible to the parents, so that they can take encouragement and make appropriate programs by observing the child's small forward steps. Otherwise most of their time will be wasted trying to teach the child large steps which are not possible without an understanding of the many intermediary stages. Or steps may be completely out of order, as when parents try to get their child writing A.B.C. before he can discriminate between a straight line and a parabola, or manipulate a pencil. The idea that the C.R. worker should merely go on exhorting the Trainer to keep trying, for six months or more without any visible progress before seeking specialist help, is naive and unrealistic. Both Trainer and C.R.W. will have become disillusioned long before, and the handicapped child will be plunged deeper into failure and opprobrium.

10) The lack of information and resources for rehabilitation even in Western developed countries, compared with what is available in the medical field, puts the C.R.W. at a further disadvantage. Family participation in rehabilitation, on a large scale, has only just begun in the West. The fact that the W.H.O. manual authors seem to know so little about it is evidence of its novelty! There seems to be some danger of rushing in with the latest Western trend as the panacea for the rural handicapped of the East.

11) Misinformation confidently given by qualified doctors, slightly garbled by the recipient and then rigidly adhered to, is also a major hazard for the C.R. worker, who will almost always have much lower status than the doctor. We have had children

removed from our school because a doctor has advised parents that "nothing can be done and it is a waste of money sending the child to a special school". A deaf child came recently whose parents had been assured by several doctors that they should not try a hearing aid until he was 12 years old. A neuro-surgeon confidently advised parents to get a baby-walker for a child who above all needed movement stimulation, which the baby-walker of course merely hampered. The senior physician at one of the Mission Hospitals was unable to distinguish polio from cerebral palsy, with consequent misdirection of the parents. A five-minute consultation with these doctors (M.B.B.S. from Medical Colleges of Pakistan), outweighs and nullifies hours of work spread over weeks by the lowly C.R. worker.

3. FURTHER PSYCHO-SOCIAL FACTORS.

In order to understand why the handicapped and disabled in developing countries are among the most neglected part of the community and are likely to remain so for many years, it is necessary to look at the background of the whole community. The majority of handicapped persons for whom no facilities or help are available live in communities where many people have a struggle for their daily bread; or where the daily bread is fairly certain but other elements of a human life with dignity are not assured. Where the majority of a community are oppressed either by physical need or fear of need, or by the grip of money-lenders, or by hard-faced employers and landlords, or by a harsh political system, or by the breakdown of family systems through migration, urbanisation and housing shortages, or as is commonly the case by a combination of several of these factors, there may be little or no surplus energy or compassion to spare for the weaker members of the community.

It has been discovered in many places and circumstances that until people achieve a certain freedom from want, until their more fundamental needs have been satisfied, e.g. for food and shelter, for loving care, purpose and personal recognition, and satisfied for sufficiently long that they no longer fear a rapid relapse into need; until this need-fulfilment is assured it is very difficult for people to develop altruistic feelings, to place themselves in the shoes (or broken feet) of others, to enter into other people's suffering and make some empathetic contribution to its relief. The people who laugh when they see a cripple dragging himself along, or a blind man bumping into an obstacle, are not necessarily vicious or barbaric. It is more likely that they have simply not had the opportunity to develop higher feelings, because of their own pinched circumstances.

This carries one difficult implication for the development of programs for handicapped persons in economically backward countries. Most development programs are beginning to see the need for involving village people and city slum-dwellers in planning and implementing their own uplift. There is the advantage that the people work for visible benefit to themselves and their families. The whole community benefits visibly when clean water comes on tap, electricity is installed, roads are built, agricultural innovations bear fruit. Whereas in the case of the handicapped, a weak, low-status and largely voiceless minority in any community, there is little visible and general benefit derived from their uplift.

The average person with a minimal standard of living can scarcely be expected to raise much enthusiasm for participating in the program when he sees no benefit for himself and his immediate family. There will of course be some noble exceptions, those rare individuals who succeed in rising above their own personal needs and circumstances, but one cannot count on finding such people. It will be sufficient advantage if cooperation can be found even in the immediate family of the handicapped person, who at least can see some benefit and have some kinship reasons for helping to rehabilitate their disabled relative. Even this is far from automatic, especially if the disabled person is female.

For the millions of families in absolute poverty, the birth of a handicapped child (or an accident or illness resulting in a serious impairment) is a blow that puts them in a slightly worse position than their neighbours. It will probably have an adverse effect on the marriage opportunities of the rest of the family. There may be unavoidable medical expense from local quacks, plus the cost of travel to shrines in search of help. There is no hope that the new child might bring any upswing in the family fortunes. Therefore, even the best-planned and executed rehabilitation program will do little more than restore them to their previous position of hovering between slight hunger and actual starvation, with chronic illness, depression and debt as their normal condition. To participate in a rehabilitation program will have only one certain effect: the rest of the village or city slum will know for sure that this family has a handicapped member, a fact which the family may have been at great pains to conceal.

Until the general level of living of the population has risen, it must be expected that the people who take any interest in the handicapped are either themselves handicapped or have attained a standard of living (both economic and emotional) sufficient for

them to look around and be moved by the needs of others. This explains why at present in Pakistan, for example, most of the people actively involved in handicap rehabilitation are either handicapped, or parents of handicapped children, and in both categories are quite well-to-do. The remainder are mostly professionals in the health, welfare or education field who have made this their specialisation for a variety of reasons. There are perhaps a few 'pure' philanthropists, and even more wealthy begums seeking personal fulfilment and the exercise of authority in a socially praiseworthy and status-boosting occupation.

Even the above thesis is open to question, when one considers the case of the Harijans of India. Like the mentally handicapped, these castless millions still suffer rejection and scarcely attain human status in the more backward areas, as a result of mistaken myths and religious notions. Like the mentally handicapped (who are still known in the west as 'Les Enfants du Bon Dieu') the Harijans (Children of God) are hardly accepted as children of men! And this continues to be the case, though to a lesser extent than formerly, despite legislation, despite the life of Mahatma Gandhi, and the fact that at least 300 million of India's population are no longer struggling in the depths of poverty. Much of the persecution in fact comes from the wealthy and powerful landlords, and the Brahmins who though often poor are highly privileged, both groups feeling threatened from beneath by the Harijans.

Similarly, rehabilitation programs for the handicapped in very poor areas must expect to run into opposition from local people, who may feel that the 'pecking order' for outside help is being disturbed. 'The handicapped, who are little more than beggars, should come at the end of the queue for assistance.' Provision of employment skills will be resented by the able-bodied unemployed; special educational measures will be opposed by parents who cannot find a school for their normal child. Even if handicap care is provided by basic health workers who also provide medical care for everyone else, it may be seen as an unwarranted intrusion into their program.

4. IGNORANCE OF THE EXPERTS.

Many obstacles impede the western Rehabilitation Adviser (WRA) in his attempts to get to grips with the situation on which he is supposed to be giving advice. There are incidental obstacles such as the differences of culture and patterns of thought; there is the obstacle of plain old-fashioned ignorance; there is the unreliability of available information including all statistics provided by third-world Governments; there are semi-deliberate obstacles placed

in his path by officials of the Government he is supposed to be advising: for reasons of pride, and occasionally from sheer bloody-mindedness, they may not wish the WRA to see things as they really are. There are whole structures of concealment built into many societies, designed to prevent those in authority from ever being confronted by stark reality. In the case of U.N. advisers there is the additional difficulty that they are obliged to keep up a fairly polite pretence of believing what they are told by their host Government, even if it is highly improbable or patently false. Most WRAs spend only a short time in the host country, and it is in the nature of their advisory position that they are rarely allowed to deal in real situations where they might bump up against lower levels of society and hear grass-roots opinions.

Even so, despite these difficulties it is singularly short-sighted (or perhaps spineless) of any WRA to visit a developing country and to fail to arrange to see a few ordinary urban and rural primary and secondary schools incognito, and a few ordinary homes with handicapped children. Without having some idea of the (generally frightful) state of normal schooling, it is impossible to make any sensible suggestions about special schooling. To ensure that such visits are genuinely incognito takes some organising, since official 'surprise' visits are invariably known to schools days in advance. Perhaps the average WRA is disinclined to rock the boat in case he or she is not asked again. However jaded, over-travelled and disillusioned they may be, most Westerners are rather pleased to be asked to be VIP guests of a foreign Government and to advise on national rehabilitation planning in return for high remuneration and red carpet, five-star hotel treatment. The number of independent commentators working in rehabilitation in developing countries, able to look critically at systems without fearing that their project may be cut, their job vanish or their visa be revoked, is small. The degree of realism in international planning and advice in this field is also by consequence rather small.

There is also a good deal of plain stupidity and lack of imagination on the part of foreign advisers, who suffer from all the hazards of international journalists, jetting from one troubled situation to another. They can easily become dog-tired and fazed by constant travel, rootlessness, temporary relationships, cumulative jet lag, chronic bowel infections and incipient alcoholism; they may withdraw from reality in a reaction to their over-exposure to culture shock; they easily develop bees in the bonnet, trotting out the same tired schemes, cliches and proposals in a dozen different countries in the course of one year. A great deal of resilience and adaptability, not common over the age of 40, is required to make a fresh start

in each place appraising the relevant cultural indicators, side-stepping the official Government bafflegab, meeting new people as people rather than as problems to be overcome, taking the time to find out what they really think and feel across the language and culture barriers. However, the requirements for becoming an 'expert adviser' tend to be long on academic qualifications and publications, and short on personal qualities; some of the people who would do a better job are not prepared to be shuttled around the world, and even if they try their hands at it will soon pack up in disillusionment. All too often the adviser is merely used for cosmetic effect to dress up mistaken policies in a respectable guise. Against these odds it is rare for advisers to remain balanced, sensible, neither too pessimistic nor euphoric, but attentive, persuasive, and confidence-building towards the Governments who invite them.

The consequent lack of realism may be seen, for example, in the world-wide promotion of breast-feeding, which is usually illustrated with busty, chocolate ladies suckling their young outside a mud hut. This image merely confirms in the minds of the highly colour-conscious third world medical personnel their previous prejudice against breast-feeding as a sort of low animal function. When the suggestion is made that breast-feeding propaganda should be illustrated with attractive pink blondes in ultra-modern Western-decor settings, it is rejected with scorn because 'village women cannot identify with the western starlet'. This of course is sheer nonsense, as can be seen from advertisements throughout the developing world, which invariably show products being used by light-skinned western types. Manufacturers trying to increase profits know more about the motivations of their clients than do western health advisers tangled up in their own body and colour prejudices. The W.H.O. Community Rehabilitation scheme compounds the above nonsense by its recommendation, in all seriousness, that mothers should wash their breasts before every feed: a suggestion which caused some amusement among a party of British women doctors who had all breast-fed their own babies, and would be quite ludicrous in the villages of half the world where there is no water on tap, and little privacy.

Ordinary commonsense is often lacking, as in the local Goitre control project for the iodisation of salt. Any ordinary stall-holder in the bazaar could have told the planners that unless the price of iodized salt was subsidised to be lower than that of ordinary salt, local people would not buy it. The fact that some foreign muck has been added which the foreigners claim will be medically helpful,

will cut no ice with the native population (whether or not the merchants of non-iodized salt spread sumours that the added muck is part of a Government sterilization program to keep down the population). Yet the U.N. agency poured in huge funds and produced iodized salt, and now sits back wringing its hands because people will not buy their product which is priced higher than ordinary salt.

There are other reasons why the hard facts spelt out in this paper are not often faced. While the WRA remains ignorant of most of them, there are nationals of various developing countries who know well enough what really goes on, but are disinclined to jeopardise their careers by publishing their thoughts. Powerful people in Government do not take kindly to the exposure of their less creditable motivations and manoeuvres, and in Asian countries there is little defence in law against the sort of pressure that the powerful can exert.

Membership of international rehabilitation bodies is often competed for by several bodies billing themselves under such titles as the Muritanian Association for the Handicapped, All-Muritania Society for Rehabilitation, National Society for Disable of Muritania and so on, which in fact operate in no more than a single city and represent a handful of people. It is not unknown for society ladies to enjoy subsidised travel abroad to conferences representing purely paper organisations. Associations may have an interest in concealing the true state of affairs in their country, both from themselves and from the international bodies. They generally hope the international bodies will give them financial and other assistance, and will help build up their little empire. Those international bodies with some experience may realise that this is the case, but may find it difficult to do anything about it, feeling that they have no righ to interfere in a country's affairs, particularly if they are suffering from post-colonial guilt. In fact, without sending representatives to live in that country and build up work from scratch, it is very difficult for international bodies to take any positive action. They may themselves even be primarily interested in adding to their own empire by recruiting members in more and more countries, regardless of the quality and activities of those members.

A1

A MIDDLE WAY IN DEVELOPING REHABILITATION SERVICES

The current state of rehabilitation services throughout Asia gives little cause for satisfaction. It has been our task over the past few years to work in Peshawar running special schools and trying to understand what is happening in the rehabilitation field and how things may usefully be developed. The current appalling state of affairs serves as a spur to better planning, which must start by a clear perception of what is going on and why it is going on. There is something rather ludicrous in the fact that the Government of this and other economically weak countries are planning highly specialised and professionalised, astronomically expensive, big-city residential institutions, while the U.N. Agencies with their highly paid staff are promoting cheap, rural, home-based general rehabilitation. Neither policy is likely to be much use in the next five years. The drawbacks of the Government schemes are well known. The U.N./W.H.O. schemes are potentially very useful, but not until there is an adequate regional support base and sufficient surplus of professional rehabilitation skill to supervise, encourage and advise the frontline community rehabilitation workers. Without such support the Community Rehabilitation schemes will do no better than the Primary Health Care schemes in similar circumstances.

There is a middle way between the expensive institution and the home-based scheme, and it is this middle way that we are promoting in the North West Frontier Province and in some nearby parts of the Punjab. How relevant it may be to other parts of the world will depend on population distribution and the temperament of the people. It is not an ideal plan, but it has already achieved some degree of mobilisation of local resources, and promises to do a good deal more.

The crucial issue is that of producing and distributing rehabilitation skills and experience, from which further strategy can emerge. The grandiose Government projects concentrate specialist skills in one place and on few clients. Even if they develop training courses, the training will be inappropriate for later application of skills in much reduced circumstances even supposing the practitioners are willing to go where they are needed. The Community Rehabilitation schemes attempt to disseminate a very low level of information and skills very widely, but will stumble through use of an inappropriate medium (the printed word) with inadequate reinforcement. The middle way aims at a modest but effective level of skill/experience, with adequate support, applied where it will have maximum usefulness. It is also open-ended both towards aiding any subsequent Community Rehabilitation scheme and towards achieving a higher level of professional ability.

The first stage, which has already been achieved, is the strengthening of an institution to become a regional resource and training centre. The Mental Health Centre in Peshawar, capital of the Province, had a playgroup for mentally handicapped children in 1977 which was enlarged over the following three years under expatriate guidance to become a day centre with 40 mentally and multiply handicapped children in attendance, a few deaf and blind pupils, a physiotherapy clinic for polio cases, and a rehabilitation and special education library. Over the past two years ten persons have received orientation courses (from 3 weeks to 4 months) with a view to setting up small schools elsewhere. Two such schools have started (one in University Town Peshawar and one in Mardan, the second city of the Frontier), one is about to start, and in a fourth town plans are being made. Efforts are also being made to set up a small intermediate technology workshop to make low-cost calipers and surgical boots. There is good liaison with local Government institutions for the deaf and the blind, so that their (admittedly meagre) professional resources can supplement the limitations of the Mental Health Centre in these handicaps.

Having established the regional base in the Provincial capital and another school in the second city, we are faced with the great mass of handicapped persons outside these cities. Certain priorities have become apparent in our experience, guided by the general principle of 'Doing the easy thing first'. It is likely that the more visible work there is with handicapped persons, the more readily can the general public be educated and staff be trained in order to improve both quality and quantity. Doing the easy thing first maximises the visible and successful impact of the modest initial inpu, and gets the snowball rolling soonest. The priorities are : 1) Towns before villages; 2) Children before adults; 3) Locally perceived needs before theoretical strategy; 4) Small scale before large scale; 5) Visible centres before invisible periphery; 6) Well-motivated parents before indifferent families; 7) Day-centres before residential work.

On this basis the easiest and most obvious thing to do is to discover well-motivated parents of handicapped children living in towns, learn from them how they perceive their problems and what they would like to do about them, and steer the action towards small local day-centres. This strategy and set of priorities maximises the likelihood of getting something viable and durable established for some handicapped children in the shortest time and at least expense in the most areas of the Frontier. If success is attained in the easiest path, more difficult ventures can then be attempted. If the easiest path proves difficult then prognosis is poor for more difficult strategies.

A project has been drawn up with U.N. assistance, to fund two Rehabilitation Development Officers (RDOs) who will work full time on the mobilisation of local community resources. They will start by following up families of 1,500 handicapped children already identified in a Survey undertaken by degree students in 1980, in towns of 50,000 population and above in the northern half of the Frontier, and conducting a Survey in the southern half. Towns of this size are spaced out across the Frontier and will eventually act as area bases for working out into surrounding rural areas (e.g. with the W.H.O. Community Rehabilitation scheme). In a town of 50,000 there will be roughly 20,000 children aged under 16, of whom 10,000 will be boys. Experience here shows that very few girls will be brought forward regularly for rehabilitative treatment, and that only about 1% of all children are perceived as handicapped by their own community. That means about 100 handicapped boys aged under 16 in our target town. It may be possible to identify and locate half of these boys. Out of their 35/40 families (since some will be brothers and many cousins) it should be possible to find 3 or 4 parents who are willing to make a determined effort and contribute their own time and money jointly to provide some facilities for handicapped children. Those minimum 3 or 4 persons will be key figures with whom the RDOs will work, forming the nucleus of a Parents' Association which will register itself with the Department of Social Welfare.

What happens next will vary from place to place depending on the local flavour of the Parents Association and their own perception and prioritisation of needs. In one place they may wish to start short occupational-skill courses for older handicapped children; in another town they may decide on a morning play-group for all handicapped under-10s; if a range of mentally retarded boys are represented, the key parents may opt for trying to start a special school for all ages of retarded children. The parents of physically disabled children might form a pressure group for an experimental integrated class at a local school for able-bodied children, and also set up an intermediate-technology caliper and boot workshop. There will obviously be a good deal of conflict at this stage, as parents will inevitably be preoccupied by the needs of their own handicapped child. In some places more than one group may form up and start separate facilities for different handicaps. It will be up to the RDOs to try to ensure that conflict is productive of action rather than anger.

Whatever the type of service decided on, the RDOs will try to steer projects towards realistic and appropriate goals reliant upon local resources. Thus projects should be planned to start initially in a very modest way using someone's big room, a family's back yard, spare space in the Community Centre, school rooms outside normal school hours, etc. Efforts will be made to get something going with neither the cost and delay of new buildings nor the problems of daily transport. One of the advantages of the medium-sized

town is that it should be possible to find some accommodation that is adequate for a modest beginning, at little cost, and located so that a sufficient number of families will be able to bring their child by their own means of transport.

The factor which will seldom be locally available is special teaching skills. That will be supplied by the regional centre giving short orientation courses (up to 3 or 4 months) to persons chosen by the Parents Association, and possibly backing them up by the loan of an experienced teacher for a few weeks to help start things up. (This should be feasible without overburdening the regional centre, because developments will inevitably take place at a different rate in the 7 or 8 target towns, so that the opening of day-centres will be staggered). It is anticipated that in some places parents themselves will give voluntary help on a rota basis, which would be easier to arrange when using school premises outside of normal working hours; in other places there will be students fulfilling their degree requirement of practical social work, Girl Guides, Red Crescent volunteers and so on, who will be able to assist if there is at least one person with some training who can give direction to the efforts.

The level of rehabilitation will be modest to start with, but once a number of small local day centres have been started it will not be difficult to arrange for the improvement of professional standards and competence. After a year or so there will be in each place perhaps half a dozen people with appreciable experience of handling handicapped children : their experience will be the base on which a tutor could build. For example, a teacher trainer could travel round giving one day per week inservice training on a different day in each town and leaving printed material to be worked through during the following week. A summer training school could be held to consolidate this experience with a better theoretical basis. Provided that people are prepared to start small and grow at a natural pace there should not be a great deal of difficulty getting things going, and once started services will not easily be stopped. Parents have greater motivation than anyone else to see something beneficial done for their handicapped child, and the greatest stamina for keeping services going.

The middle way described here is probably the easiest method of keeping the child in his normal family environment, while taking some of the burden off the parents. The expensive, specialised big-city services say 'Give us your handicapped child and we will assume the entire burden' (but they say it to extremely few); the Community Rehabilitation scheme says 'No, he's all yours, you must keep him and help him at home'. The middle way gives the parents, especially the mothers, a break from their child and gives the child a break from his family, while being close enough to the home to be able to enlist family cooperation and participation. Giving the child a chance to make fresh relationships from scratch can be a very big step towards rehabilitation : often

in addition to the initial impairment the handicapped child suffers from intense and long-standing hang-ups within the family, due sometimes to over-protection, under-stimulation, being allowed to run wild, or other attitudes not conducive to balanced behaviour. The family too is enabled to see the child through fresh eyes and with a new reserve of patience gathered during the spell of blessed peace and quiet while he is out of the home.

Apart from catalysing and motivating local parents, guiding them towards realistic and appropriate goals, liaising with local health, education and welfare professionals and coordinating the activities with the regional centre, the RDOs will undertake several subsidiary projects. The need will arise for a variety of cheap, robust equipment, most of which can be made by local carpenters and metal workers if simple diagrams and measurements are provided. Written reports on progress of various aspects of their work should form the basis for a Guide and Handbook for parent groups elsewhere who wish to start their own small rehabilitation service. Training and advisory material will be produced with help from the regional centre, for teachers, skill instructors, parents and local health, education and welfare professionals. Detailed child development observation and assessment charts will have to be drawn up with appropriate cultural adaptation. Simple methods must be devised and appropriate material written for training Mother and Child Health centre staff to carry out elementary Hearing, Sight and Mental ability testing of young children. If the RDOs have an aptitude for it they may attempt a general systems-analytical description of Handicap in the towns of the North West Frontier Province, with help and guidance from the regional centre, which will also provide relevant material from various parts of the world for all the above exercises.

For appropriate skills training there will need to be a study to identify common, inexpensive marketable items which require few components, simple tools and no very complicated processes, e.g. raffia fans and mats, rubber buckets and flower pots (from old tyre rubber), chicken wire, candles, twine and rope, netting, clothes pegs, gummed cardboard boxes, paper bags, various sorts of brush, simple carved toys. These items should be written up from supply and cost of raw materials through the necessary tools and processes, to local market outlets for the finished product. If skills centre are set up for older handicapped children they should aim within a finite time period, perhaps 6 months, to teach each child how to make at least two or three items out of a dozen or more possibilities, and then to take in a new group of handicapped children and repeat the process. This will avoid the customary decline of the vocational training centre, in which the first intake of trainees stay on for many years, perhaps paying their way but preventing any turnover of trainees.

Again, the level of training is not very high and the finished products may barely show a profit, but the change in social position of the young handicapped person will be considerable if he is able to sit at home either by himself or with other handicapped persons for company and mutual support making something of recogniseable usefulness. The alternative is often nothing more than beggary or complete oblivion dozing in a corner. Where it is possible for girls to get training, the elements of domestic science will probably be most appropriate, since women in the Frontier spend almost all their life at home.

The RDOs will be responsible for the introduction of creative thinking and experiments with new possibilities in vocational training. Discussion in this area so far, in Pakistan, has not got beyond the assumption that there are only two settings for economic activity by handicapped persons : either free labour market status or sheltered workshops. Whereas publications by the International Labour Office list more than ten times this number of types of economically useful activity, which may work out in several thousand different employment situations. It will be the exacting but rewarding task of the RDOs to bring such alternatives to the attention of local Associations who are otherwise unlikely to break new ground.

Financing the above schemes from local resources should not be much of a problem. The sort of families whose attitude is to get something done for themselves rather than expecting the Government to do everything for them, are also the families who can find money when they want to do something. The principal running costs of the schemes envisaged will be the salary of the teacher or skill-trainer. Most of this could be met from the joint pockets of 6 or 8 average families whose handicapped child was benefitting. (In fact, if certain standards are met the Education Ministry may be prepared to pay a teacher's salary, since all children have a constitutional right to education and the Government is not of itself providing appropriate schooling for the handicapped). Capital grants for equipment are not difficult to find, either from Government or from larger charitable organisations, Zakat Foundation, Embassy and U.N. staff and so forth. Local notables and other wealthier people, banks and factories, the big pharmaceutical companies, women's organisations and so on will all be sources of annual donations. Services for handicapped children, once they have started and something is visibly going on, are popular objects for charitable impulses, since they have a deserving image and are non-political and non-sectarian.

U.N. funding for the RDOs may last two or three years, until local projects are firmly established. If Government continues the project, it will at least know that it is funding a successful effort which with a modest investment pays big returns in the mobilisation of local community resources. In any case, established local centres will continue with assistance from the regular Social Welfare officers posted in every town.

WHAT ABOUT THE VILLAGES ?

The concern shown by some Western advisors for 'the villages of Asia' is not entirely unrealistic, though it is often romanticised and sometimes heavily coloured by experience in African nations where very different social customs and systems prevail. The projects and principles described above are not done in ignorance of the fact that 80% of the population live in rural villages. Rather they are seen as an essential preliminary step towards reaching the rural masses. On the basis of Primary Health Care experience it appears that without adequate back-up services, the Community Rehabilitation scheme envisaged by the W.H.O. will have little success. The setting up of some rehabilitation work in the towns throughout the Frontier will provide a focus for interest and concern, and small resource bases from which Community Rehabilitation schemes could start. (The preventative and educative aspects of the W.H.O. scheme can be going on all along, through village development workers and health education personnel, but those aspects are not strictly speaking 'rehabilitation'.)

Once it becomes known that something has started in the town for the handicapped, there will be families coming in from rural areas to see what is being done and to seek help for their handicapped child. In addition to on-the-spot counselling, they could be given some of the W.H.O. material to work through, and be advised to come back after a month or so to check progress. (This already happens in Peshawar, with families coming in from up to 300 miles away for advice, and returning periodically). There will be an element of self-selection in this : the families who make their way to the town will be the more highly motivated ones, who will tend also to persevere with such material and advice as they are given. When some experience has been built up in this way of parent counselling and using the W.H.O. material, it may be possible to place the material more widely, e.g. in M.C.H. centres of surrounding rural areas, with a short orientation course for the M.C.H. centre staff so that they can act as a distribution base and first point of enquiry for parents with handicapped children. Later still, on the basis of the experience gained in these ways, it may be possible to extend the service by sending out general rehabilitation aides with the W.H.O. material (much revised and improved by this time) to contact mothers in their homes.

FUTURE SHOCK NOW

The few ideas outlined above are for the most part rather obvious, and have had some success in various parts of the world at different times. However, they derive from the past and are no more than temporary expedients, doing what lies immediately to hand. Planning for the 1980s should not be confined within a framework of ideas and aspirations from the 60s and 70s. Changing social and economic conditions are rushing headlong upon the provincial towns of Asia, leaving many traditional systems high and dry, many people bewildered and fearful, many leaders on the retreat from reality, and handicapped people as usual at the end of every queue and the bottom of every pile.

It is clear that there is insufficient political skill and will among national politicians throughout Asia to achieve the sort of redistribution and appropriate application of resources that could lead to "Primary Health Care for All by 2000 A.D.", let alone "Primary Rehabilitation for All Handicapped Persons". Just as there seems little likelihood of the wealthier nations redistributing their wealth and power in any significant degree towards the poorer nations, it is wishful thinking to imagine that the able-bodied public in Asia is going to give anything more than cosmetic aid to handicapped people. If the poorer nations and handicapped persons manage to arrive at a better position, it will be almost entirely through their own efforts.

Those of us who are concerned for the rights of handicapped persons to lead lives with some degree of human worth and dignity must consider what sort of societies are likely to exist in ten and twenty years time, and what tools or weapons we can provide to handicapped persons now to enable them to survive, to battle, and to achieve worthwhile goals, in a world where less and less even of able-bodied people will obtain remunerative employment or have any real control over the circumstances of their own lives.

'Education', which used to be the world panacea for a bleak future, has not been tried and found wanting, but rather has been tried and found difficult and has been substituted by 'schooling', a process of rote-learning and ideological indoctrination that is responsible for greater handicapping of the human mind and spirit than all biomedical factors and other environmental influences put together. To submit already disabled children to this stultifying practice by attempting widespread integration into the normal schooling system as it presently exists, is as little future-orientated as to add 'Molotov cocktails' to the list of common, inexpensive items which handicapped persons might be trained to make.

Welfare programs, including those for the handicapped, are certainly seen in no more favorable terms by one of the better known exponents of grass-roots development, Paulo Freire : 'They act as an anaesthetic, distracting the oppressed from the true causes of their problems. They splinter the oppressed into groups of individuals hoping to get a few more benefits for themselves' (Pedagogy of the Oppressed', tr. Ramos, 1972). It would be interesting to try some of Friere's adult literacy techniques for self-liberation, with disabled persons. This could take place anywhere in the world, and with any of the varieties of handicap. It has been established that people learn to read very much more quickly and develop thinking and reflective capacity, when the material on which they start is a matter of intense personal and political interest to them. For adult mentally retarded persons who wish to learn to read, a literacy primer should be prepared that would cover the struggles for independence of a mentally retarded person, the various trials, obstacles and psychiatrists he or she overcomes, and the eventual triumph of independent living. Intellectually demanding equivalents are not difficult to imagine for non-literate adults with other handicaps.

Another technique which we hope to try out here in Peshawar is the use of training in thinking, decision-making, analysis and such-like mental and life skills. Since it has been established by De Bono and others that such skills can be taught, and should be taught, but very rarely are taught and certainly not in the schooling system prevailing throughout the developing world, this presents an opportunity particularly for the physically disabled and blind persons (i.e. those handicapped persons who have less communication problem) to develop these skills and to use them to win a place of respect in their community. Such skills are not immediately marketable in the way that basket-weaving is, but they are rarer and more valuable and in the long run one handicapped person who has learnt, developed and begun to apply creative thinking to his own life, his family and surrounding community, should be able to outstrip any ten basket-weavers both economically and in every other sphere (provided he avoids being shot or hanged as a revolutionary.)

Next should come perhaps some training in Information and Propaganda Science. Access to, and retrieval of information, presentation of propaganda, rhetoric and oratory, methods of duplication and dissemination, graphics, manipulation of the mass media etc., which at present are picked up with painful trial and error over many years by a tiny handful of spokesmen for the handicapped, should be made available to all who are capable of benefitting. So far, the 'image of the handicapped' has been dictated by non-handicapped persons. The future must see a new set of images controlled by handicapped persons, so that they can come to know themselves as truly human men and women and let the general public know the same.

The learning of such skills requires very little in the way of equipment, plant, materials etc., certainly compared with the sort of investment usually required for sheltered workshops or vocational training institutes. It does require initially some persons who are themselves possessed of communication and thinking skills, and who realise that they can be taught as such. Once started, handicapped persons themselves can continue the work of helping others to learn to think, to develop ideas and to communicate them persuasively. Such ideas are too esoteric and threatening of 'normal schooling' to catch on readily among the community at large, in which parents are pre-occupied by the necessity of their offspring memorising the prescribed text-books in order to move up the education ladder. But that is where the handicapped person has an advantage, being largely neglected by the schooling system and not labouring under the burden of such high parental expectations.

Even for the backward or mentally retarded person it has been shown by De Bono's Cognitive Research Trust that considerable progress can be achieved and that this has a liberating effect on the person who is accustomed to failing in the usual grind of 'knowing the right answer'. When introduced to questions which have ten or more answers, the relative merits of which may be examined and kicked about, there is more opportunity for the slower thinker to gain a feeling of success and control over ideas.

Politicised literacy, access to information, creative thinking and methods of propagating ideas, all seem to have great potential for unleashing the hidden and pent-up energies of handicapped persons all over the world, and for equipping them to fight their own battles in the ever more complex muddle of clashing cultures and disintegrating social systems which can safely be predicted for the next decade.

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INTEGRATED EDUCATION FOR HANDICAPPED PUPILS :
SOME PRACTICAL DRAWBACKS IN DEVELOPING COUNTRIES

It is often suggested that the integration of handicapped children into the normal education system should be part of the rehabilitation program in developing countries, avoiding the provision of expensive special educational arrangements which will never be available to more than a small proportion of handicapped children. It is suggested that since the education system in most developing countries is in no hard and fast state, and is constantly growing, it would be more sensible to make plans for integration sooner rather than later. Furthermore, the benefits to handicapped children of living as normal a life as possible, including mixing with non-handicapped children from the earliest years, are now increasingly acknowledged.

Before swallowing these arguments it is worth looking at the condition of normal schooling and asking how far it is likely to benefit handicapped children. In doing so it must be remembered that practically all senior Government officials, and certainly all Western education advisors, have themselves conformed to the requirements of normal schooling from the age of 5 to 23 or more, and so may not be the most objective of critics of the system; and that the quality of schooling they have had will almost always have been among the best available in their country, a very long way from the quality of the poor or average schooling which is all that would be available for 90% of handicapped children.

Schooling, as currently performed or purveyed throughout the developing world and in the less privileged sections of the richer nations, is a process whereby a thin veneer of conformity and 'civilisation' is enforced inexpertly upon the young, whether noble or ignoble, generally by hired hacks from the lower middle classes. I speak from personal teaching experience in council housing estates in England, and that experience is echoed by relatives and colleagues from all over Britain. It was again my experience and observation in Togo, West Africa, and is my observation in Pakistan and India. Apparently Mr. Ivan Illich sees much the same in Latin America. It is confirmed by every non-Government report I have ever read that set out to evaluate what really goes on in the non-privileged classrooms of the world. It is not necessarily a bad thing; it may be a necessary feature of development and modern life. But it is best to look at it realistically, and not imagine that there is any panacea for the handicapped to be found in integration with the normal system of schooling.

In most parts of the world, the daily business of schooling includes certain rituals designed to reinforce a respect for, or at least a fear of, authority as embodied in the teacher and the head teacher above him It involves the transfer of certain mechanics and data (e.g. reading, writing and the rules of arithmetic) from the teacher to the pupils, by means of repetition, exercises and parroting. When the mechanics are grasped, there is the business of memorising text-books approved by the Government, which contain further sets of data with a historical, religious or idealogical slant, so that the mass of children may grow up believing certain things without question; indeed without there being the possibility of them questioning. Questioning, independent thought, anything that originates with the child rather than the teacher, is assumed to be an attack on the teacher's authority and in consequence an attack on the Authority Principle, and is put down with more or less force.

In most places schooling is a competitive business. Pupils compete with one another for the approval of the teacher, for being first with the 'right answer', for gaining top marks by regurgitating the memorised portions most accurately. Any connection with real life, experience and hard, nobbly facts, vanishes before the textbook-memorise-regurgitate juggernaut. The best-known local illustration concerns the question set in a public examination, "What is the capital of Pakistan?" Those children who wrote correctly 'Islamabad' were marked wrong, because the textbook showed the capital as 'Karachi' (which was correct when the textbook was printed, some while before).

By the age of 7 a child at one of the more competitive schools is taking home 4 hours worth of memorisation to complete for the next day. The amount may be less at schools lower down the pecking order, but from those the child takes home (and carries about with him everywhere) a greater burden still: the knowledge that he has already begun to fail; he has not succeeded in gaining admission to the school of choice; his family are already disappointed. The situation is similar in most parts of Asia. The incidence of suicide among Japanese school-children indicates that it may be even worse there.

An obsession with marks, percentages and examination results distorts the whole system, inevitably attracting widespread attempts to cheat, to buy exam papers beforehand, to bribe examiners or to substitute papers. This sort of thing also goes on in highly developed countries but is kept in check by long-established guidelines, traditions, and by the sheer weight of well-educated and responsible people available to run the system. Where such numbers are lacking, and it is possible for wealthy people to pay colossal bribes for their children to be passed up the schooling ladder, it is inevitable that

the system becomes corrupt (whether or not the degree of competition is itself corrupting).

The system is characterised by a complete absence of the child-centred, exploratory, learning-through-doing approach, based on modern understanding of child development and cognitive processes. Even where it is understood that such methods might produce better results there is no way to break into a closed system with so much ambition and pressure holding it together. A few teachers in Karachi are trained privately in the Montessori method of education, but very few find a school in which they are able to practise this method, despite Government recognition of the qualification. (The Montessori-trained Principal of a local teacher training college brings her students to our school as the only place in the Province where she can show them what she is talking about!)

The Government may understand and deplore the half-baked products and the miserable wastage from its schooling system, but public pressure is too great for there to be any radical measures to reform. There are not nearly enough normal schools for the ever-increasing flood of children. There are not enough teachers, and the entry standard and training required inevitably drops, so that barely literate young people stand before their crowded classes, painfully dinning into them the same dismal cant and hotch-potch they learnt themselves just as painfully ten years before. Education Ministries become preoccupied with merely increasing the number of school buildings, desks, blackboards, teachers; with finding the salaries; with making sure that the teachers in remote areas actually turn up to school regularly rather than just collecting their pay; with trying to ensure that the village school building is not turned into a grain store by the local farmers.

Where attention is paid to the content of schooling it tends to be on nationalistic lines, and the demand is for inculcating religious values and indoctrination with national ideology, often in pathetic competition with the 'parallel schooling' of the media, wherein children learn, with every modern trick of brain-infiltration and subliminal programming, that Coca Cola, Honda motorcycles, fancy wrist-watches and smart clothes are the real stuff of Life.

Vastly more is spent on the upper reaches of the system so that the medical and engineering students (who generally come from wealthy homes where textbooks and tutors can be afforded) have the most spent on them by the Government. Thus the privilege of the wealthy is readily maintained. In theory the system is open to all, and the

schooling may be free. In practice, success depends on paying the teachers for private coaching, and being able to pay for all the 'extras' of books and materials, and possibly bribes in the right quarters.

These facts are familiar to everyone in the education world of developing countries, though they are not often published. There is little prospect of improvement in the next ten years; in fact the pressure of population is likely to make things worse. (The position of girls, so far as access and persistence in the system is, anyway, worse than that of boys). The benefit to handicapped children of participation in this shambles must therefore be highly questionable even if it were considered feasible by Governments which already cannot cope with the demand from non-handicapped children.

When integration schemes are proposed in the wealthier nations there is always a wave of protest from the teaching profession and from parents of non-handicapped children, and that is in the relatively favourable conditions of having classes with no more than 30/35 pupils, an adequate number of schools and all manner of supportive services. When it is a case of classes with between 50 and 80 children and neither time nor thought for individual attention, there seems little prospect of successful integration other than for those children with a mild impairment, and such children hardly count as 'handicapped' in the less developed countries.

The first reason given by teachers, parents and officials for rejecting the idea of integration is likely to be none of the above (which are in any case too painful to admit). The universal answer, based presumably on experience and observation, is that the handicapped child would be subjected to intolerable teasing and cruelty by the other children. (This, interestingly enough, was the reaction even from the Director of a Special School in Leningrad, interviewed by Victoria Shennan, despite the heavy ideological programming towards mutual assistance and acceptance). Although UNESCO studies have attempted to show that prejudice against the handicapped is a learned reaction, which children would not necessarily develop if adult society did not teach it to them, nevertheless it is perfectly obvious that such a change in adult attitudes will take very many years to bring about, even in countries with powerful disability organisations working towards this objective.

Despite all the foregoing remarks, we are attempting in Peshawar to investigate the current minimal enrolment of physically disabled

children in normal schools, and to promote its increase, using at first those schools where the head teacher is known to be favourably inclined. Our reasons are that the physically disabled have the least difficulty among the handicapped in coping with the current methods of schooling and some of them must be capable of rising to the top of the ladder by applying themselves (having fewer distractions than other children), and from these future well-qualified handicapped persons may come some advocacy of handicapped people by handicapped people. For the same reason we support and are trying to improve the existing few special schools for the deaf and the blind, so that they too (who would certainly be lost in the normal system) may produce some leaders and advocates. The benefit to the individuals is incidental to the strategy, though of course it is far from incidental to the children themselves and their families.

As a footnote on integration, interchange and normalisation, we recall one of our earliest pupils, a boy who was presented as being 'mad', i.e. severe and violent behavioural disturbance, from a family of smugglers living at the head of the Khyber Pass. He was, in fact, rather bright, and at 9 years old had so mastered the reading of non-verbal signals that his family refused to believe that he was stone deaf, which our instruments revealed. Once this diagnosis was made and appropriate measures taken to teach him, his behavioural problems rapidly diminished and he started making progress with writing and arithmetic, quickly outstripping his mentally handicapped fellow-pupils. After a year the family came to say that he would not attend any further, thanking us for curing his 'madness', still firmly rejecting any suggestion of deafness, and stating that they had got him admitted to a normal school with his brothers so that he would not seem too different from them. We could only applaud the latter sentiment, though we knew that he would within six months have fallen behind the normal classroom work. But in any case, he and his brothers were not expected to waste very much time in school, before joining the family business, where keen eye-sight and the ability to handle rifles and camels would be of more use!

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